Every Woman Matters

NEBRASKA OFFICE OF WOMEN'S HEALTH

DHHS NEBRASKA

301 Centennial Mall South, P.O. Box 94817
Lincoln, NE 68509-4817
Phone: 1-800-532-2227 Fax: (402) 471-0913

Client Informed Refusal

Directions for form:

1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3, and all gray shaded areas.

Version: October 2009

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352. The Nebraska Department of Health and Human Services provides language assistance at no cost to limited English proficient persons who seek our services.

All the shaded area must be complete.

Client Name _____ DOB: _____ SSN#: _____ Name of Procedure/Treatment: _____

Section 1:

Date _____/_____/_____

I, _____ have been informed by my healthcare provider, that I should
(please print your name)

have this test/treatment below. This test/treatment is: _____

_____.
(please print in your own words, the name of the test/treatment and why it is being done)

If I do not get this test/treatment I know these things may happen to me:_____

_____
(please print in your own words what can happen if the test/treatment is not done)

- ■ I have had the need for this test/treatment explained to me.
- ■ I know that not having this test/treatment at this time, is against my healthcare provider's advice and may be harmful to my health. My abnormality may be a sign of a potential serious medical condition, including cancer.
- ■ I know what this test/treatment is for. I know why I need it. I know how it is done.
- ■ I know that signing this form does not stop me from having this evaluation/procedure/treatment done later.
- ■ I know how to get money to help me pay for the test/treatment.
- ■ I know that I am still a part of Every Woman Matters (EWM) if I am a female over 40 years of age.
- ■ I know that I can reapply later to EWM if I am a female and under 40 years of age.
- ■ I know that I can reapply to the Nebraska Colon Cancer Screening Program (NCP), if I am a male or female 50 years of age or older.
- ■ I have read all the information above and know what it means. I am choosing to refuse the above test/treatment at this time.

Client Signature _____ Date _____/_____/_____

Section 2:

Submitted by:

- ❑ Clinic
- ❑ Case Manager
- ❑ Outreach Worker
- ❑ EWM/NCP Central Office

_____ Date _____/_____/_____

Facility/Clinic/Agency Information - clinician name, clinic name, city name ***(do not abbreviate)***

Portion below to be completed ONLY if client unable to write or has language barrier.

If client unable to write information herself; the client will dictate the information and the form should be witnessed by two individuals.

Dictated by _____ Date _____/_____/_____
Please Print Client Name

Written by_____ Date _____/_____/_____
Person taking the dictation

Witnessed by:

1. _____ Date _____/_____/_____

2. _____ Date _____/_____/_____

Interpreted by: _____ Date _____/_____/_____
If Interpreter Needed

Complete reverse side only if unable to obtain a signed Client Informed Refusal

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Service Provider Documentation

Version: October 2009

Directions for form:

1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3, and all gray shaded areas.

***All the shaded area must be complete.**

Client Name _____ DOB: _____ SSN#: _____ Name of Procedure/Treatment: _____

Section 3:

Provider has insured that the client has enough information to make an informed decision.

Client Informed Refusal given to client: ❑ Yes ❑ No on Date _____/_____/_____

Client Informed Refusal given to client by:

- ❑ Personal Contact / In the Office
- ❑ Phone Contact
- ❑ Postal Contact

❑ Client returned Client Informed Refusal incomplete.

❑ Client failed to return a signed Client Informed Refusal.

_____ Date _____/_____/_____

Facility/Clinic/Agency Information - clinician name, clinic name, city name ***(do not abbreviate)***

Attempts were made to give information to the client regarding:

- ❑ Diagnostic Services
- ❑ Diagnosis
- ❑ Treatment Services
- ❑ Treatment

Provider is unsure if the client has or is able to make an informed decision due to one or more of the following reason(s):

- ❑ No verbal communication with client
- ❑ Low literacy level
- ❑ Language / Translation issues
- ❑ Mental / Emotional disability
- ❑ Visual / Hearing impairment

_____ Date _____/_____/_____

Facility/Clinic/Agency Information - clinician name, clinic name, city name ***(do not abbreviate)***

Name of Person completing this form: _____

_____ Date _____/_____/_____

Facility/Clinic/Agency Information - clinician name, clinic name, city name ***(do not abbreviate)***

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